**DEPARTMENT OF SOCIAL SERVICES**
744 P Street, Sacramento, CA 95814

February 11, 1997

ALL COUNTY INFORMATION NOTICE I-06-97

REASON FOR THIS TRANSMITTAL

[ ] State Law Change
[X] Federal Law or Regulation Change
[ ] Court Order
[ ] Clarification Requested by One or More Counties
[X] Initiated by CDSS

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: CHANGES TO FORMS USED BY THE AID TO FAMILIES WITH DEPENDENT CHILDREN, FOOD STAMPS, AND MEDI-CAL/ STATE-RUN COUNTY MEDICAL SERVICES PROGRAMS

REFERENCE: ALL COUNTY LETTERS NO. 96-51 and 96-60

This letter transmits changes to the application and monthly/status report forms. Copies of the following forms are enclosed:

- CA 7 (12/96), Monthly Eligibility Report
- SAWS 7 (12/96), Monthly Eligibility/Status Report
- CA 7A (12/96), How to Fill Out Your CA 7 and SAWS 7
- SAWS 1 Coversheet and SAWS 1 (12/96), Application for Cash Aid, Food Stamps, and Medi-Cal/State-Run County Medical Services Program (State CMSP)

Below is a description of the general changes to the forms. Attachment 1 outlines all changes not discussed below. It is recommended that counties begin using the forms transmitted in this notice as soon as administratively feasible.

CA 7 and SAWS 7

County Welfare Departments (CWDs) are advised that effective immediately, the forms designation for the CA 7 and SAWS 7 is changed from "Required Form - No Substitute" to "Required Form - Substitute Permitted." By changing the form designation for the CA 7/SAWS 7, CWDs will no longer be required to ask the state for a waiver to conduct a demonstration project when proposals involve only minor changes to the form.

Additionally, CWDs will have more flexibility in addressing individual variations for county systems and/or demographic characteristics, which should reduce the need for county developed supplementary forms.

However, there is no change in the requirement for CWDs to obtain prior approval from the California Department of Social Services (CDSS) before implementing a modification of or substitution to the CA 7/SAWS 7 and other "Substitute Permitted" forms. For the Aid to Families with Dependent Children (AFDC) and/or Food Stamp (FS) Programs, the procedures for submission of a change request are outlined in Management and Office Procedures Regulations 23-400.22.

For Medi-Cal changes or substitutions to the SAWS 7 and the MC-176, Medi-Cal Status Report Form, CWDs should contact the Department of Health Services, Medi-Cal Eligibility Branch.

There are other revisions to the CA 7 and SAWS 7. The forms are changed to facilitate the identification of persons eligible for the higher Maximum Aid Payment as referenced in All County Letter (ACL) No. 96-60. Also, the new FS disqualification penalties are incorporated in the Certification Section.

CA 7A

The CA 7A is revised to provide the recipient with specific information on how to complete the CA 7 and SAWS 7. The prior version did not include information regarding the SAWS 7.

SAWS 1

The SAWS 1 Coversheet is revised to eliminate narrative regarding homelessness as a basis for FS Expedited Service. See ACL 96-51 for a discussion of this issue. The SAWS 1 Application is not revised.

## CAMERA-READY COPIES AND TRANSLATIONS

Counties needing a camera-ready copy of any of the forms discussed in this letter may call the Forms Management Unit at (916) 657-1907 or CALNET 437-1907 for copies of the English and Spanish (SP) versions. For Asian language (Chinese, Cambodian, and Vietnamese) versions, counties may FAX their requests to the Language Services Bureau at (916) 657-3429 or CALNET 473-3429. Counties may call (916) 464-1282 if only one form is being ordered.

A camera-ready version of the SAWS 1 (SP) is expected to be available within 30 days. Camera-ready versions of the SP translations of the remaining forms and the Asian translations of all forms are expected to be available at a later date.

STOCK

A six-month supply of state produced stock for the English language versions of all forms are expected to be available in the CDSS Warehouse by March 21, 1997. The SP translations are expected to be available at a later date. CDSS will issue the Notice of Change Form (GEN 127) when the English and Spanish language versions of the forms are available. See the County Forms Catalog for the procedures for ordering forms from the CDSS Warehouse.

CONTACTS

If you have any questions or need further information, please contact the following staff regarding the specific program areas:

- This letter and the forms: Elizabeth Allred at (916) 657-3350/CALNET at 437-3350;
- Food Stamp Program: Melissa Buchanan at (916) 654-8467/CALNET at 464-8467;
- Asian/Spanish translations: Shirley LuKung at (916) 654-1277/CALNET at 464-1277;
- Medi-Cal: Michelle Harrison at (916) 654-6469/CALNET at 464-6469 or Kveta Simon at (916) 657-2767/CALNET at 437-2767.

Sincerely,

Bruce Wagstaff

BRUCE WAGSTAFF
Deputy Director
Welfare Programs Division

Attachments

c: CWDA
Frank Martucci, Department of Health Services

CA 7/SAWS 7

Changes common to both forms:

- The first bullet at the top of the page is revised to "Complete, sign, and return this report by the 5th of the month. Facts on who can sign are listed above the signature blocks on page 2."

- Item 1, narrative in the first bullet is streamlined. The adjectives "Number of" and "Gross" are inserted in the subset grid as "Number of Days and Hours Worked" and "Gross Amount."

- Item 2 is revised to add "seeking work." This narrative, only for FS households, is relocated from old item 5 on page 2 "Dependent Care...."

- In Item 3 the adjective "Gross" is inserted in the subset grid as "Gross Amount."

- Item 4a is deleted as this information is not required. Prior item 4b is renumbered as item 4.

- Page 2 is reformatted to provide space for new item 5. Subsequent items are renumbered.

- New item 5 asks "Did anyone become disabled, or recover from a disability/major illness? Include anyone who is unable to work for at least 30 days." Subset items ask the recipient to identify the name of person(s), relationship, date of change, and what changed. The change in disability status was requested in old item 6 (as a subset item in column 1). New item 5 was developed for AFDC purposes to identify potential eligibility for an exemption to the MAP cuts as referenced in ACL 96-60. However, narrative is not limited to that issue as this item also obtains disability status for FS and Medi-Cal/State CMSP.

- New item 6, narrative is streamlined.

- New item 7, is reformatted to insert a grid to obtain specific subset information. Other changes to the forms include:

  - The prior "Disability" bullet is relocated to new item 5 as outlined above.

  - The "Citizenship/Immigration Status" bullet is revised to "...gets a new card, form or letter from the INS."

- The prior "Dependent Child Care" bullet is deleted with the exception of the phrase "seeking work," which is relocated to item 2.

- The "IHSS" bullet is added to identify potential eligibility for an exemption to the MAP cuts.

o The "ADDRESS CHANGE" section is streamlined.

o The "CERTIFICATION SECTION" is resequenced to separate the penalties for welfare fraud for cash aid and FS. Narrative is updated and clarified.

- Old bullet two "If I have any doubts about needing to report any changes, I must contact my worker" is deleted. This information is on other documents provided to the client at time of application and recertification.

- Old bullet three "Facts I report may result in benefits going up, down, or being stopped" is relocated to new bullet five at the top of page 1.

- Old bullet eight is revised to "If I file more than one application so I can get cash aid in more than one case at the same time, or ..." and is relocated to new bullet 4.

- In the "WHO MUST SIGN BELOW" section narrative is streamlined.

CA 7 Only Change

o Bullets three and four in the introductory section are reversed.

SAWS 7 Only Changes

o The narrative "Attach a separate sheet of paper if needed" (from the second sentence, first bullet in Part A) is relocated to bullet 4 in the instructions section at the top of the form.

o In PART A the title is changed to "Request to Stop Benefits." The term "Medical Assistance" is changed to "Medi-Cal" and a new checkbox and narrative are added for "State CMSP."

o In PART B the first two sentences in the first bullet are deleted as this narrative essentially duplicates the instructions in bullet 4 in the instructions section "If you want to keep your benefits...."

o In the "CERTIFICATION SECTION" bullet two narrative regarding the timeframe for reporting Medi-Cal/State CMSP changes is combined with the timeframe narrative for cash aid in bullet one.

CA 7A

The CA 7A is a document used by the eligibility worker at intake to orally discuss with clients the procedures for completing the report form. The CA 7A may be provided to recipients at any other time, such as at recertification or when the recipient does not complete the CA 7 or SAWS 7 correctly. The CA 7A is updated and made more user friendly. Changes include reformatting to two-columns, simplifying and resequencing narrative. Instructions for completion of the SAWS 7 are added.

- The form title is changed to "HOW TO FILL OUT YOUR CA 7 OR SAWS 7."

- Introductory bullets provide the names of the forms, instructions on answering questions, asking for help to complete the form if needed, attaching proof, signing the form, etc.. New bullet three explains how the county uses the information that is provided, i.e., "...to see if you are still eligible for benefits and to figure the amount of cash aid or benefits you should get."

- Page 1, column one provides instructions on program specific completion criteria, such as reporting timeframes, and information about the consequences of perjury and fraud.

- On page 1, column two, a new section is added "HOW TO FILL OUT PART A ON THE SAWS 7." The "FACTS YOU MUST REPORT FOR EACH ITEM" section explains the information that must be reported for each item number.

- On page 2, the first column discusses "PROOF."

- On page 2, the second column provides definitions of some terms on the CA 7, SAWS 7 and/or CA 7A. The reminder section is revised and retitled "DO NOT FORGET!"

SAWS 1 COVERSHEET

- Page 1, second column, Expedited Service (ES), the first bullet is deleted as homelessness or temporary housing no longer qualifies as a reason for FS ES.

- Page 2, first column, the description of State CMSP is simplified to "medically necessary emergency care for adults who are not on Medi-Cal and who live in some rural counties."

- Page 2, bullet 3 in the "OTHER THINGS YOU SHOULD KNOW" section regarding "Fraud and Perjury" is revised to clarify that the applicant/recipient swears "under oath" to tell the truth when he/she signs a penalty of perjury statement. Bullet 4 narrative is revised to begin "If you are found guilty of committing fraud..."

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

# MONTHLY ELIGIBILITY REPORT

## For Cash Aid and Food Stamps

WORK PAYS IN SO MANY WAYS

THIS REPORT IS FOR THE MONTH OF

- Complete, sign, and return this report by the 5th of the month. Facts on who can sign are listed in the CERTIFICATION section.
- **If a complete report is still not in by the 11th, your benefits for cash aid, food stamps, and/or Medi-Cal/State CMSP may be delayed, lowered or stopped. You will not get work allowances for cash aid.**
- If you get food stamps, answer for everyone in your household. If you don't get food stamps, answer for everyone on cash aid including children, parents, stepparents and your spouse.
- Answer ALL questions below and **attach proof** when we ask for it or your benefits may be lowered or stopped. Attach a separate sheet of paper if needed.
- Facts you report may result in your benefits going up, down, or being stopped.

Need Help? Call your worker. Worker: Phone:

**(1) Did anyone get money from a job or training program?** ☐ YES ☐ NO

- If "YES", complete below. Include tips, vacation pay or income in kind, such as earned housing. List gross amounts before deductions and actual date received. Check ( ✔ ) if for job or training. **Attach paystubs or other proof of earnings.**
- **If self-employed**: List business costs on a separate sheet of paper and **attach proof** of income and costs.

| Who Got Income | Employer's name ☐ Job ☐ Training | Number of Days Worked | Number of Hours Worked | Gross Amount $ Date Received | Gross Amount $ Date Received | Gross Amount $ Date Received | Gross Amount $ Date Received | Gross Amount $ Date Received |
|---|---|---|---|---|---|---|---|---|
| Who Got Income | Employer's name ☐ Job ☐ Training | Number of Days Worked | Number of Hours Worked | Gross Amount $ Date Received | Gross Amount $ Date Received | Gross Amount $ Date Received | Gross Amount $ Date Received | Gross Amount $ Date Received |

**(2) If anyone above paid for care of a child, disabled person or other dependent while working, seeking work, or in training, list here and attach proof of payment.**

| Name Of Person Who Received Care | Cost | Name Of Person Who Received Care | Cost |
|---|---|---|---|
| | $ | | $ |

**(3) Did anyone receive money or benefits from any other source?** ☐ YES ☐ NO

Include: Child/spousal/medical support; interest from checking/savings accounts or CDs; stock or bond dividends, etc.
Social Security; Supplemental Security Income/State Supplemental Payment (SSI/SSP); railroad retirement; veterans.
Workers Compensation; state disability insurance (SDI); unemployment; other disability; strike benefits.
Lump sums - back government benefits; lottery winnings; money from insurance/legal settlements, etc.
Cash; gifts; loans; grants; scholarships; tax refunds; rental income; free housing, utilities, or food; or anything else.

If YES, list who received, source, gross amount and actual date received. **Attach proof.**

| Who Got Income | Source of Income | Gross Amount $ Date Received | Gross Amount $ Date Received | Gross Amount $ Date Received | Gross Amount $ Date Received | Gross Amount $ Date Received | Gross Amount $ Date Received |
|---|---|---|---|---|---|---|---|
| Who Got Income | Source of Income | Gross Amount $ Date Received | Gross Amount $ Date Received | Gross Amount $ Date Received | Gross Amount $ Date Received | Gross Amount $ Date Received | Gross Amount $ Date Received |

**(4)** If anyone paid court ordered child support this month, list the amount they paid and report any changes in the court order. **Attach Proof.**
**$**

COUNTY USE ONLY E.W. INITIALS DATE:

**(5) Did anyone become disabled, or recover from a disability/major illness? Include anyone who is unable to work for at least 30 days? If "YES", complete below:** ☐ YES ☐ NO

| FULL NAME OF PERSON(S) | RELATIONSHIP TO YOU | EXPLAIN WHAT CHANGED | DATE OF CHANGE |
|---|---|---|---|
| | | | |

**(6) Did anyone move into or out of your home, or did you move in with some one else? Include: newborns; temporary absences; anyone who died, entered or left a hospital, etc. If "YES", complete below:** ☐ YES ☐ NO

| FULL NAME OF PERSON(S) | RELATIONSHIP TO YOU | EXPLAIN WHAT CHANGED | DATE OF CHANGE |
|---|---|---|---|
| | | | |

**(7) Does anyone have anything else to report? Include expected changes. Attach proof, including any costs.** ☐ YES ☐ NO
If "YES", complete below:

- **Income:** Starts, changes or stops.
- **Job/ Training:** Start, stop, quit, refuse a job or training, go out on strike, **or** a change in number of hours.
- **School:** Start or stop school or college. Costs for tuition, school transportation, etc.
- **Property:** Buy, sell, trade, give away, or get a motor vehicle, home, land, or trusts, etc.
- **Checking/ Savings:** Open/close a checking or savings account(s) or the balance is different at the end of the month.
- **Citizenship/ Immigration Status:** A citizenship or immigration status changes or anyone gets a new card, form or letter from the INS.
- **Babies:** Become pregnant, have a baby, abort or miscarry.
- **Marital:** Marry, divorce, or separate.
- **Medical Costs:** **For Food Stamps:** anyone who is disabled or age 60 or older **may report new** medical costs not being used to figure your current allotment.
- **Insurance:** Start, stop, or change life, dental or health insurance benefits including MEDICARE coverage.
- **IHSS:** Starts or stops In-Home Supportive Services.

| NAME OF PERSON(S) | RELATIONSHIP TO YOU | EXPLAIN WHAT HAPPENED | DATE OF CHANGE |
|---|---|---|---|
| | | | |
| | | | |

## ADDRESS CHANGE

Fill in this section ONLY if you have moved or have a new mailing address. And if you get food stamps, **attach proof** of your **new** housing costs, such as rent and utility receipts/bills.

| NEW HOME ADDRESS (NUMBER, STREET NAME, AVENUE, BLVD., ETC.) APT NO | CITY | STATE | ZIP CODE | NEW PHONE NUMBER |
|---|---|---|---|---|
| | | | | ( ) |

| DATE MOVED | NEW MAILING ADDRESS (IF DIFFERENT FROM HOME ADDRESS) | CITY | STATE | ZIP CODE |
|---|---|---|---|---|
| | | | | |

## CERTIFICATION

**I UNDERSTAND THAT:**

- I must contact my worker within 5 days of any change that may affect my eligibility for or the amount of my cash aid.
- I have the right to a state hearing on any proposed action by the county welfare department.
- **If on purpose I don't report all facts or give wrong facts to get or keep getting aid or benefits, I can be legally prosecuted and can be charged with committing a felony if more than $400 is wrongly paid out for cash aid, food stamps, or cash-based Medi-Cal because I did not report all of my facts or changes in income, property, or family status.**
- **If I do not follow cash aid rules, my cash aid can be stopped for 6 months for the first violation, 12 months for the second, and forever for the third. And I may be fined up to $10,000 and/or sent to jail/prison for 5 years.**
- **If I file more than one application so I can get cash aid in more than one case at the same time, or give the county false proof for an ineligible child or for a child that does not exist, my cash aid can be stopped for 2 years, 4 years, or forever.**

**I ALSO UNDERSTAND THAT:**

- **If I do not follow food stamp rules, my food stamps can be stopped for 12 months for the first violation, 24 months for the second, and forever for the third. And I may be fined up to $250,000 and/or sent to jail/prison for 20 years.**
- **If I am found guilty in any court of law because:**
  - **I traded or sold food stamps for firearms, ammunition, or explosives, my food stamps can be stopped forever for the first violation;**
  - **I traded or sold food stamps for controlled substances, my food stamps can be stopped for 24 months for the first violation and forever for the second;**
  - **I traded or sold food stamps that were worth $500 or more, my food stamps can be stopped forever;**
  - **I gave the county false identity or residence information, so I can get food stamps in more than one case at the same time, my food stamps can be stopped for 10 years.**
- **Any member of my household who is hiding or running from the law for a felony, an attempted felony, or a parole or probation violation cannot get food stamps.**

**(8) YOU MUST SIGN AND DATE THIS REPORT AFTER THE LAST DAY OF THE REPORT MONTH OR IT WILL BE CONSIDERED INCOMPLETE.**
**I declare under penalty of perjury under the laws of the United States and the State of California that the facts contained in this report are true and correct and complete for the entire report month.**

**WHO MUST SIGN BELOW:** **For Cash Aid**: you, your spouse and the other parent (of aided-children) if living in the home.
**For Food Stamps**: the head of household, a household member or the household's authorized representative.

| SIGNATURE OR MARK | DATE SIGNED | HOME PHONE | CONTACT PHONE |
|---|---|---|---|
| ☛ | | ( ) | ( ) |

| SIGNATURE OF SPOUSE OR OTHER PARENT OF CASH-AIDED CHILDREN | DATE SIGNED | SIGNATURE OF WITNESS TO MARK, INTERPRETER OR OTHER PERSON COMPLETING FORM | DATE SIGNED |
|---|---|---|---|
| ☛ | | ☛ | |

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
DEPARTMENT OF HEALTH SERVICES

# MONTHLY ELIGIBILITY/STATUS REPORT

**For Cash Aid, Food Stamps and Medi-Cal/State-Run County Medical Services Program (CMSP)**

WORK PAY$ IN SO MANY WAYS

THIS REPORT IS FOR THE MONTH OF

- Complete, sign, and return this report by the 5th of the month. Facts on who can sign are listed in the CERTIFICATION section.
- **If a complete report is still not in by the 11th, your benefits for cash aid, food stamps, and/or Medi-Cal/State CMSP may be delayed, lowered or stopped. You will not get work allowances for cash aid.**
- **Important:** If you don't want cash aid, food stamps and/or Medi-Cal/State CMSP anymore, fill in PART A below, sign and date Item (8) on the back of this form.
- If you want to keep your benefits, fill in ALL questions in PART B below and **attach proof** when we ask for it or your benefits may be lowered or stopped. Attach a separate sheet of paper if needed.
- Facts you report may result in your benefits going up, down, or being stopped.

Need Help? Call your worker. Worker: Phone:

**PART A Request to Stop Benefits** (If you fill in this part, sign and date Item (8) on the back of this form.)

I ask that my ☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal be stopped on the last day of: _____ MONTH/YEAR

I know that I may reapply at any time. ☐ State CMSP

**PART B** If you get food stamps, answer for everyone in your household. If you don't get food stamps, answer for everyone on cash aid and/or Medi-Cal including children, parents, stepparents and your spouse.

(1) **Did anyone get money from a job or training program?** ☐ YES ☐ NO

- If "YES", complete below. Include tips, vacation pay or income in kind, such as earned housing. List gross amounts before deductions and actual date received. Check ( ✔ ) if for job or training. **Attach paystubs or other proof of earnings.**
- **If self-employed:** List business costs on a separate sheet of paper and **attach proof** of income and costs.

| Who Got Income | Employer's name ☐ Job ☐ Training | Number of Days Worked | Number of Hours Worked | Gross Amount $ Date Received | Gross Amount $ Date Received | Gross Amount $ Date Received | Gross Amount $ Date Received | Gross Amount $ Date Received |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| Who Got Income | Employer's name ☐ Job ☐ Training | Number of Days Worked | Number of Hours Worked | Gross Amount $ Date Received | Gross Amount $ Date Received | Gross Amount $ Date Received | Gross Amount $ Date Received | Gross Amount $ Date Received |
| | | | | | | | | |

(2) **If anyone above paid for care of a child, disabled person or other dependent while working, seeking work, or in training, list here and attach proof of payment.**

| Name Of Person Who Received Care | Cost | Name Of Person Who Received Care | Cost |
|---|---|---|---|
| | $ | | $ |

(3) **Did anyone receive money or benefits from any other source?** ☐ YES ☐ NO

Include: Child/spousal/medical support; interest from checking/savings accounts or CDs; stock or bond dividends, etc. Social Security; Supplemental Security Income/State Supplemental Payment (SSI/SSP); railroad retirement; veterans. Workers Compensation; state disability insurance (SDI); unemployment; other disability; strike benefits. Lump sums - back government benefits; lottery winnings; money from insurance/legal settlements, etc. Cash; gifts; loans; grants; scholarships; tax refunds; rental income; free housing, utilities, or food; or anything else.

If YES, list who received, source, gross amount and actual date received. **Attach proof.**

| Who Got Income | Source of Income | Gross Amount $ Date Received | Gross Amount $ Date Received | Gross Amount $ Date Received | Gross Amount $ Date Received | Gross Amount $ Date Received | Gross Amount $ Date Received |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| Who Got Income | Source of Income | Gross Amount $ Date Received | Gross Amount $ Date Received | Gross Amount $ Date Received | Gross Amount $ Date Received | Gross Amount $ Date Received | Gross Amount $ Date Received |
| | | | | | | | |

(4) If anyone <u>paid</u> court ordered child support this month, list the amount they paid and report any changes in the court order. **Attach Proof.**
$

COUNTY USE ONLY E.W. INITIALS DATE:

**(5) Did anyone become disabled, or recover from a disability/major illness? Include anyone who is unable to work for at least 30 days? If "YES", complete below:** ☐ YES ☐ NO

| FULL NAME OF PERSON(S) | RELATIONSHIP TO YOU | EXPLAIN WHAT CHANGED | DATE OF CHANGE |
|---|---|---|---|
| | | | |

**(6) Did anyone move into or out of your home, or did you move in with some one else? Include: newborns; temporary absences; anyone who died, entered or left a hospital, etc. If "YES", complete below:** ☐ YES ☐ NO

| FULL NAME OF PERSON(S) | RELATIONSHIP TO YOU | EXPLAIN WHAT CHANGED | DATE OF CHANGE |
|---|---|---|---|
| | | | |

**(7) Does anyone have anything else to report? Include expected changes. Attach proof, including any costs.** If "YES", complete below: ☐ YES ☐ NO

- **Income:** Starts, changes or stops.
- **Job/ Training:** Start, stop, quit, refuse a job or training, go out on strike, **or** a change in number of hours.
- **School:** Start or stop school or college. Costs for tuition, school transportation, etc.
- **Property:** Buy, sell, trade, give away, or get a motor vehicle, home, land, or trusts, etc.
- **Checking/ Savings:** Open/close a checking or savings account(s) or the balance is different at the end of the month.
- **Citizenship/ Immigration Status:** A citizenship or immigration status changes or anyone gets a new card, form or letter from the INS.
- **Babies:** Become pregnant, have a baby, abort or miscarry.
- **Marital:** Marry, divorce, or separate.
- **Medical Costs:** **For Food Stamps:** anyone who is disabled or age 60 or older **may report new** medical costs not being used to figure your current allotment. **For Medi-Cal/State CMSP:** medical costs that were due to an injury or accident caused by someone else.
- **Insurance:** Start, stop, or change life, dental or health insurance benefits including MEDICARE coverage.
- **IHSS:** Starts or stops In-Home Supportive Services.

| NAME OF PERSON(S) | RELATIONSHIP TO YOU | EXPLAIN WHAT HAPPENED | DATE OF CHANGE |
|---|---|---|---|
| | | | |

## ADDRESS CHANGE

Fill in this section ONLY if you have moved or have a new mailing address. And if you get food stamps, **attach proof** of your **new** housing costs, such as rent and utility receipts/bills.

| NEW HOME ADDRESS (NUMBER, STREET NAME, AVENUE, BLVD., ETC.) APT NO | CITY | STATE | ZIP CODE | NEW PHONE NUMBER |
|---|---|---|---|---|
| | | | | ( ) |

| DATE MOVED | NEW MAILING ADDRESS (IF DIFFERENT FROM HOME ADDRESS) | CITY | STATE | ZIP CODE |
|---|---|---|---|---|
| | | | | |

## CERTIFICATION

**I UNDERSTAND THAT:**

- I must contact my worker **within 5 days** of any change that may affect my eligibility for or the amount of my cash aid or **within 10 days** of any change that may affect my eligibility or share of cost for Medi-Cal/State CMSP.
- I have the right to a state hearing on any proposed action by the county welfare department.
- **If on purpose I don't report all facts or give wrong facts to get or keep getting aid or benefits, I can be legally prosecuted and can be charged with committing a felony if more than $400 is wrongly paid out for cash aid, food stamps, or Medi-Cal because I did not report all of my facts or changes in income, property, or family status.**
- **If I do not follow cash aid rules, my cash aid can be stopped for 6 months for the first violation, 12 months for the second, and forever for the third. And I may be fined up to $10,000 and/or sent to jail/prison for 5 years.**
- **If I file more than one application so I can get cash aid in more than one case at the same time, or give the county false proof for an ineligible child or for a child that does not exist, my cash aid can be stopped for 2 years, 4 years, or forever.**

**I ALSO UNDERSTAND THAT:**

- **If I do not follow food stamp rules, my food stamps can be stopped for 12 months for the first violation, 24 months for the second, and forever for the third. And I may be fined up to $250,000 and/or sent to jail/prison for 20 years.**
- **If I am found guilty in any court of law because:**
  - **I traded or sold food stamps for firearms, ammunition, or explosives, my food stamps can be stopped forever for the first violation;**
  - **I traded or sold food stamps for controlled substances, my food stamps can be stopped for 24 months for the first violation and forever for the second;**
  - **I traded or sold food stamps that were worth $500 or more, my food stamps can be stopped forever;**
  - **I gave the county false identity or residence information so I can get food stamps in more than one case at the same time, my food stamps can be stopped for 10 years.**
- **Any member of my household who is hiding or running from the law for a felony, an attempted felony, or a parole or probation violation cannot get food stamps.**

**(8) YOU MUST SIGN AND DATE THIS REPORT AFTER THE LAST DAY OF THE REPORT MONTH OR IT WILL BE CONSIDERED INCOMPLETE. I declare under penalty of perjury under the laws of the United States and the State of California that the facts contained in this report are true and correct and complete for the entire report month.**

**WHO MUST SIGN BELOW:** **For Cash Aid**: you, your spouse and the other parent (of aided-children) if living in the home.
**For Food Stamps**: the head of household, a household member or the household's authorized representative.
**For Medi-Cal/State CMSP**: you, your spouse or the person acting for the beneficiary.

| SIGNATURE OR MARK | DATE SIGNED | HOME PHONE | CONTACT PHONE |
|---|---|---|---|
| ☛ | | ( ) | ( ) |

| SIGNATURE OF SPOUSE OR OTHER PARENT OF CASH-AIDED CHILDREN | DATE SIGNED | SIGNATURE OF WITNESS TO MARK, INTERPRETER OR OTHER PERSON COMPLETING FORM | DATE SIGNED |
|---|---|---|---|
| ☛ | | ☛ | |

# HOW TO FILL OUT YOUR CA 7 OR SAWS 7

- **Save this notice and use it to help you fill out your CA 7 (Monthly Eligibility Report) or SAWS 7 (Monthly Eligibility/Status Report). If you need help filling out your report, tell your worker.**
- **Answer each question on the report. If you say "YES", you must give more facts and attach proof when we ask for it. Sign and date the CA 7/SAWS 7 in item ⑧, certification section. Do not date the report before the first of the report month that is shown at the top right hand corner of your form.**
- **The county uses the facts you give on your report to see if you are still eligible for benefits and to figure the amount of cash aid or benefits you should get.**


## HOW OFTEN YOU MUST COMPLETE A CA 7/SAWS 7

You must turn in a complete CA 7/SAWS 7:

- For Cash Aid and Food Stamps: every month.
- For Medi-Cal Quarterly Reporting and State-Run County Medical Services Program (CMSP): only when the county sends or gives your one.

## REPORTING FOR PERSONS THAT ARE IN YOUR HOME

**If You Get Cash Aid (No Food Stamps), Report Facts for:**

- All children - natural, adopted, stepchildren.
- Children's parents - natural, adopted, stepparents.
- Other aided relatives of the children.
- Anyone who is temporarily absent from the home/household.

**If You Get Cash Aid and Food Stamps or Food Stamps Only, Report Facts for:**

- All children.
- All related adults.
- Others who buy or prepare food with you.

**If You Get Medi-Cal/State CMSP, Report Facts for:**

- Your children - natural, adopted, stepchildren.
- Children's parents - natural, adopted, stepparents.
- Yourself and your spouse.

## WHO MUST SIGN THE REPORT

- **For Cash Aid:** you and your spouse and/or the other parent (of the aided children) if living in the home.
- **For Food Stamps:** the head of household, a household member, or the household's authorized representative.
- **For Medi-Cal/State CMSP:** the applicant, applicant's spouse or the person acting for the beneficiary.
- **And** any other person who fills out the report, an interpreter, or the witness to your mark.

## PENALTY OF PERJURY

- You sign the report "under penalty of perjury." This means that you swear under oath that the facts you give us are true, correct, and complete.
- Perjury and Fraud are crimes. If **on purpose** you give us facts that are not true, correct, and complete, you will be investigated for fraud and:
  - You can be legally prosecuted with penalties of a fine, jail/prison, or both. You will have committed a felony if you get more than $400 wrongly paid out to you.
  - For cash aid and food stamps, you can get a disqualification penalty that stops your benefits for 6 months, 12 months, 2 years, 4 years, or forever.
  - You may have to pay back any cash aid, food stamps, or Medi-Cal/State CMSP you should not have gotten.

## HOW TO FILL OUT PART A ON THE SAWS 7

**Request to Stop Benefits**

- **On the SAWS 7,** complete Part A only when you want to stop any of your benefits.
- Check what benefits you want stopped and tell us the date you want them stopped.
- If you ask to have your cash aid stopped, your Medi-Cal may also be stopped.
- You must sign and date the SAWS 7 in item ⑧.

## FACTS YOU MUST REPORT FOR EACH QUESTION

**For Item Number:**

① Any earnings and training allowances anyone got. Tell us the name of the person(s) who got the income/training allowances, the days and hours they worked, gross amount received and the actual date received. If self-employed, list all business expenses on a separate sheet of paper.

② Your child care costs or costs to take care of a disabled person or other adult while working, seeking work, or in training.

③ Any other money anyone got, such as: Child or spousal support, Social Security, Supplemental Security Income/State Supplementary Payment (SSI/SSP), Unemployment/Disability Insurance, lottery winnings, lump sum, etc. List who got the income, gross amount, and date received.

④ Any court ordered child support you paid and any changes to the court order.

⑤ Facts about anyone who became disabled or recovered from a disability or major illness.

⑥ Facts about anyone who moves into or out of your home. If someone moves into someone else's home, explain whose home and relationship. Include temporary absences from the home.

⑦ Other facts that could change your eligibility or the amount of your benefits, like starting or stopping a job, school or training; changes in the balances in your checking/savings accounts; buying or selling something; a change in immigration status; or anything else. Include any changes you expect to happen in the next 30 days. If you get Food Stamps and you are disabled or age 60 or older, you **may report new** medical costs not being used to figure your current allotment.

**ADDRESS CHANGE:** Give us any changes in your address or phone number.

**SEE OTHER SIDE FOR MORE INFORMATION**

## PROOF

**You Must Send in Proof Only When We Ask for It, Such As:**

- For earnings or training allowances.
- For costs for care of a child or disabled adult.
- When money or benefits start, stop, or the amount changes.
- When there is a change in the court order or the amount of court ordered child support payments you pay.
- When your health insurance starts, stops, or changes,
- If you move and get food stamps, include proof of your new housing and utility costs.
- When you get married or divorced, become pregnant or have a baby.

**Examples of Proof for Income and Training Allowances:**

- Original paystubs that show the name of the employer and the person who worked, the gross amount of pay before deductions, dates of the pay period, etc.
- If self-employed: Copies of quarterly/annual income tax reports, monthly profit and loss statements, etc.
- Copies of checks, award letters, loan papers, or other papers that show where the money came, from the amount owed or received, and the name of the person who got or will get the money, benefit, or free item, such as housing or utilities.

**Examples of Proof for Expenses/Costs:**

- **If self-employed:** copies of signed receipts, cancelled checks, statement(s) of charges from the person/firm providing an item(s) or service(s).
- **For care** of a child, or other dependent so someone can go to work or training: attach copies of receipts, bills, or cancelled checks that show the cost of the care and the names of the persons who received care, who paid for the care, and who gave the care.
- **For housing and utility costs:** receipts or bills for rent, mortgage, utilities.
- **For college or trade school:** copies of statement(s) from school or an award letter showing financial aid, tuition, fees, and other school costs.

**Examples of Other Proof:**

- **For pregnancy:** copy of the doctor's or clinic's statement that gives the mother's name and the date the baby is due.
- **For changes in citizenship/immigration status:** a copy of a letter, form or new card from the Immigration and Naturalization Service (INS).
- **For marriage or divorce:** a copy of a marriage license or divorce papers.

## WHAT WE MEAN WHEN WE SAY

**COMPLETE CA 7/SAWS 7:** A CA 7/SAWS 7 is "complete" **only** when:

- all the YES/NO questions are answered, **and**
- all the information is filled in, **and**
- all proof is attached when we ask for it, **and**
- all required signatures are on the form, **and**
- the form is signed and dated after the last day of the report month.

**COURT ORDERED CHILD SUPPORT:** The payment a court of law or other legal document says you must make to a person for a child who are not in your home. Include payments made by a stepparent.

**GROSS AMOUNT:** The amount of your paycheck before deductions are taken out for taxes, social security, etc.

**HOUSING COSTS:** Rent or house/mortgage payments; insurance and property taxes when they are not part of your house/mortgage payment.

**LUMP SUM:** Lump sum is income you may get just one time or only once in a while, such as back government benefits, court awards, lottery winnings. etc.

**REPORT MONTH:** The month shown at the top right hand corner of page one of the CA 7/SAWS 7.

**STATE CMSP:** Medically necessary benefits for eligible adults who are not eligible for Medi-Cal and who live in some rural counties.

**TRAINING ALLOWANCE:** The money you get while you are in training.

**UTILITY COSTS:** For a Food Stamp household costs for heating/cooling, phone, etc.

**DO NOT FORGET!**

- **If your report is late, not complete, or not turned in, your benefits may be late, lowered or stopped.**
- **If your report is not complete when you turn it in, you will be asked to complete it again.**
- **If a complete report is not received by the 11th of the month, you will not get work deductions for cash aid.**
- **If you sign and date your report before the last day of the report month, you will be asked to sign and date it again.**
- **If you are not sure how to report, what to report, or what proof you need to send in, ask your worker.**

# COVERSHEET TO THE APPLICATION FOR CASH AID, FOOD STAMPS, AND/OR MEDI-CAL/STATE-RUN COUNTY MEDICAL SERVICES PROGRAM (STATE CMSP)

TO APPLY FOR CASH AID, FOOD STAMPS, AND/OR MEDI-CAL/STATE CMSP, complete Items 1-13 on the attached application, and sign the Certification Section (Item 19). Give the form to the welfare office. If you have a disability and need help applying for or continuing to receive cash aid, benefits, and services, tell the county.

BEFORE YOU CAN GET CASH AID, SUCH AS HOMELESS ASSISTANCE OR IMMEDIATE NEED; FOOD STAMPS, INCLUDING EXPEDITED SERVICE; OR MEDI-CAL/STATE CMSP you must give us all the facts we ask for on your written Statement of Facts and/or answer questions during your eligibility interview. We use the facts you give us to figure eligibility and benefits.

TO GET AFDC IMMEDIATE NEED AND/OR AFDC HOMELESS ASSISTANCE, you must appear to be eligible for AFDC. Complete the attached form and give us the facts we ask for. You may need to meet some rules, such as giving us your Social Security Number(s), trying to get income available to you, and agreeing to cooperate with the district attorney about child, spousal, and medical support.

FOR FOOD STAMPS, the application can be filled in and signed under penalty of perjury by either an adult household member or by an authorized representative. If you are not an adult member of the household, you must have a written note signed by the head of household or another household member saying that you can apply for the household, pick up their food stamps, and/or use the food stamps to buy food for the household.

## AFDC IMMEDIATE NEED

If you have an emergency, you may be able to get up to $200 while we work on your application. You will need to tell us about your emergency situation and you will need to show that you don't have the income or money to pay for these emergencies:

- Lack of housing or lack of food
- Eviction notice
- No utilities or utility shut-off notice
- Lack of essential clothing
- Essential transportation needs not met
- Other kinds of emergencies important to health and safety.

If your Immediate Need request is turned down, you can ask for it again during the time we work on your application. Let the county know if something changes.

## AFDC HOMELESS ASSISTANCE

If you are homeless, and want to apply for homeless assistance, tell the county. Homeless Assistance is available once in a lifetime, with exceptions.

## CALIFORNIA ALTERNATIVE ASSISTANCE PROGRAM (CAAP)

CAAP can help pay your child care costs if you are working and approved for cash aid, but choose not to get cash aid. You will get Medi-Cal and may be able to get food stamps. You can only choose to be in CAAP at the time of application for AFDC or at the annual review of your eligibility for AFDC.

**APPLICANTS FOR FOOD STAMPS:** All you have to do the day you apply is give us your name and address, tell us you want food stamps (Item 8) and sign the application (Item 19). Before we can tell if you are eligible, you must give us all the facts we ask for on your written Statement of Facts and/or answer questions during your eligibility interview. You should be told if you are eligible within 30 days after you apply.

Food Stamps — Date of Eligibility

If you are eligible for food stamps, we will figure your benefits from the date you apply. You can apply for food stamps the first day you contact the welfare office.

## FOOD STAMP EXPEDITED SERVICE

You may have the right to get food stamps within three days. Your household must be eligible for the Food Stamp Program AND HAVE

- rent or mortgage and utility costs that are more than your liquid resources and this month's income before deductions **(see the other side of the page for definitions of income and liquid resources),**

OR

- no more than $100 liquid resources and less than $150 income for the month before deductions,

OR

- no more than $100 liquid resources and at least one member who is a migrant or seasonal farmworker.

Before you can get food stamps within three days, **complete Items 1 - 17 on the attached application**; give us all the facts we ask for during your eligibility interview; and give us proof of your identity.

## MEDI-CAL/STATE CMSP - MEDICAL EMERGENCY/ PREGNANCY

If you have a medical emergency or are pregnant AND want Medi-Cal as soon as possible, complete Items 1-14. You must also give all the facts we ask for during your eligibility interview and meet all eligibility requirements.

## MEDI-CAL PRESUMPTIVE ELIGIBILITY (PE) FOR PREGNANT WOMEN

If you are pregnant, you may get temporary Medi-Cal from certain medical providers for many prenatal care services before applying for regular Medi-Cal. Ask your doctor or clinic if they offer PE. If you apply for AFDC or Medi-Cal by the end of the month after the month you get a PE card, your temporary Medi-Cal will continue until aid is approved or denied. If you are getting PE, check "YES" in both parts of Item 12 and tell the county.

TURN PAGE OVER FOR MORE INFORMATION

## WHAT WE MEAN WHEN WE SAY:

- **California Alternative Assistance Program (CAAP):** child care payments and Medi-Cal, for working individuals who are eligible for AFDC, but who choose not to get cash aid.
- **Cash Aid:** AFDC (Aid to Families with Dependent Children) and Refugee Cash Assistance.
- **Food Stamps:** benefits for low income households to help buy food.
- **Food Stamp Expedited Service:** food stamps within 3 days.
- **Medi-Cal:** medically necessary benefits for eligible persons.
- **Medi-Cal Presumptive Eligibility (PE):** temporary Medi-Cal coverage from certain doctors or clinics for many out-patient prenatal care services.
- **Restricted Medi-Cal:** emergency and pregnancy related care only.
- **Authorized Representative:** a person picked by an applicant or recipient for food stamps and/or Medi-Cal, who can take care of some of their business.
- **Head of Household:** a responsible member of the food stamp household.
- **Income:** money received or expected, such as:
  - earnings, welfare, child support, Supplemental Security Income/State Supplementary Program (SSI/SSP) or Social Security, pension or retirement payments;
  - Unemployment Insurance Benefits (UIB), State Disability Insurance (SDI), Veterans Benefits (VA), or other disability payments;
  - strike funds; payments from roomers and boarders; school grants and loans;
  - cash gifts, cash winnings, any other cash payments.
- **Liquid Resources:** other money, such as:
  - cash on hand, uncashed checks; money in checking accounts, savings accounts; or saving certificates;
  - trust deeds, notes receivable, stocks or bonds, etc.
- **State CMSP**: Medically necessary benefits for eligible adults who are not on Medi-Cal and who live in some rural counties.
- **Restricted State CMSP**: Emergency care only.
- **Utilities:** gas, electricity, heating fuel, telephone (basic rate), utility installation, garbage and trash pickup, water, sewage, etc.
- **You, Anyone, Everyone:** any and all persons who live in your home.

## OTHER THINGS YOU SHOULD KNOW:

- You can apply for cash aid and food stamps at the same time and have one interview for both.
- You have the right to fill out this form yourself or, if you ask, have someone help you.
- **FRAUD AND PERJURY:** Fraud and perjury are crimes. The law says you must sign a penalty of perjury statement on most forms to get and to keep getting cash aid, food stamps, and Medi-Cal. Perjury means that you swear under oath to give true, correct and complete facts. If you lie about facts or **on purpose** do not give us all the facts or situations that affect your eligibility and aid payment levels, you can be charged with fraud.
- **If you are found guilty of committing fraud, you may be fined up to $10,000 for cash aid and $250,000 for food stamps and/or sent to jail/prison for 5 years for cash aid and 20 years for food stamps. Cash aid and food stamps can be stopped for six months, twelve months, two years, four years, or forever.**
- **OVERPAYMENTS/OVERISSUANCES** – means you got more aid or benefits than you should have gotten.
  - **If it's your fault:** you will have to pay it back and your cash aid or food stamps will be lowered or stopped. Your Medi-Cal/CMSP share of cost may be changed.
  - **If it's the County's fault:** For AFDC, you will have to pay it back and your cash aid will be lowered or stopped. For food stamps, your benefits will not be lowered or stopped, unless you agree to have this done.
- **SOCIAL SECURITY NUMBER (SSN) RULES** - We computer match SSNs against records from tax, welfare, employment, the Social Security Administration and other agencies to be sure you are reporting all your income and resources. We may check out differences with employers, banks, and/or others. We also match SSNs to be sure that you aren't getting aid in more than one case, or in another county or state.

  **Cash aid and food stamps:** You must give us the SSN for each applicant/recipient for cash aid and/or food stamps. If you refuse to give us either the SSN or proof of application for the SSN, you won't be able to get cash aid or food stamps. For cash aid, you must give us your SSN(s) or proof of application for the SSN within 30 days of application and give the SSN to the county when you get it.

  **Medi-Cal:** Each applicant for Medi-Cal who has a SSN is asked to give it to the county. Any U.S. citizen, U.S. national, amnesty alien with a valid and current I-688, alien with lawful permanent residence in the U.S. (LPR), or alien permanently residing in the U.S. under color of law (PRUCOL) who refuses to give a SSN or proof of application for a SSN, will not be able to get Medi-Cal/State CMSP. Any alien who does not have an SSN and who is not an amnesty alien with a valid and current I-688 or an LPR or PRUCOL, can still get restricted Medi-Cal/State CMSP if he/she meets all eligibility rules, including California residency.

## COMPLAINTS

If you think you have been discriminated against, contact your county's civil right's representative or write to:
State Civil Rights Bureau
P.O. Box 944243
Sacramento, CA 94244-2430
or by calling collect (916) 654-2107
or for the hearing impaired TDD
1-(800) 654-2098

For other kinds of complaints, contact your county first. If you and the county can't agree, write or call to:
Public Inquiry and Response (PIAR)
744 P Street, M.S. 16-23
Sacramento, CA 95814
Phone 1 - (800) 952 - 5253
or for the hearing impaired
TDD 1 - (800) 952-8349

## STATE HEARINGS

If you do not agree with any action taken by the county, you can ask for a State Hearing by writing to your local county welfare office or by calling one of the phone numbers listed for PIAR above if you are asking for a state hearing for cash aid, food stamps, Medi-Cal, or if you think you are not getting *the right State CMSP services*. To appeal *all State CMSP eligibility issues*, you can **only write** to your county. You must ask for the hearing within 90 days of the county's action and you must tell why you want a hearing.

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
DEPARTMENT OF HEALTH SERVICES

# APPLICATION FOR CASH AID, FOOD STAMPS, AND/OR MEDI-CAL /STATE CMSP (SAWS 1)

Before completing this application, read the coversheet. If you need more space to answer, write on the back of this sheet.

1. NAME OF APPLICANT (FIRST, MIDDLE INITIAL, LAST)

2. SOCIAL SECURITY NUMBER (SSN)

3. MAIDEN OR OTHER NAME (IF ANY)

4. HOME ADDRESS: NUMBER STREET
CITY ZIP CODE

5. MAILING ADDRESS (IF DIFFERENT)
CITY ZIP CODE

6. TELEPHONE NUMBER(S): HOME WORK MESSAGE

7. Is your home address permanent? ☐ YES ☐ NO ☐ NO HOME
If not permanent, please explain:

8. Is anyone applying for: Cash Aid ☐ YES ☐ NO Medi-Cal ☐ YES ☐ NO
Food Stamps ☐ YES ☐ NO State CMSP ☐ YES ☐ NO
Any Other Program(s) ☐ YES ☐ NO If YES, explain:

9. Has anyone ever asked for or gotten aid or benefits, including Medi-Cal/Medicaid? ☐ YES ☐ NO
If YES, list: Name(s) used, where (county, state, country), when, type(s) of aid or benefit:

10. The law says we must record your ethnic group and language. This won't affect your eligibility.
**a. Ethnic Group** ☐ White ☐ Hispanic ☐ Black ☐ Filipino ☐ Guamanian
☐ Asian Indian ☐ Alaskan Native ☐ American Indian
☐ Laotian ☐ Cambodian ☐ Japanese ☐ Korean ☐ Chinese ☐ Samoan
☐ Vietnamese ☐ Hawaiian ☐ Other Asian or Pacific Islander (Specify):

**b. Language** ☐ English ☐ Cantonese ☐ Lao ☐ Tagalog ☐ American Sign
☐ Spanish ☐ Cambodian ☐ Vietnamese ☐ Russian ☐ Other (Specify):_____

11. Is anyone a migrant or seasonal farmworker? ☐ YES ☐ NO

12. Is anyone pregnant? ☐ YES ☐ NO If YES, did she get a Presumptive Eligibility card? ☐ YES ☐ NO

13. Does anyone have a personal emergency? If YES, check (✔) type: ☐ YES ☐ NO
☐ Immediate Medical Need ☐ Pregnancy ☐ Child Abuse ☐ Spousal Abuse
☐ Elder Abuse ☐ Other emergency which threatens health or safety: Explain:

**IF YOU NEED: AN AFDC IMMEDIATE NEED PAYMENT.....FILL IN ITEMS 14 - 18.**
**FOOD STAMP EXPEDITED SERVICE.....FILL IN ITEMS 14 - 17.**
**MEDI-CAL OR ARE PREGNANT AND HAVE AN IMMEDIATE MEDICAL NEED.....FILL IN ITEM 14.**

14. How much liquid resources does everyone, including children, have?
☐ Cash, uncashed checks or money orders $_____
☐ Checking/savings or credit union account(s) $_____
☐ Trust deeds, notes receivable, stocks or bonds $_____
☐ Other (explain) $_____

15. How much income did everyone, including children, get or will they get this month?

| Date | Amount | Date | Amount |
|---|---|---|---|
| _____ | $_____ | _____ | $_____ |
| _____ | $_____ | _____ | $_____ |

16. How much is your rent or mortgage this month?
$ _____

17. How much are your utilities that are not included in your rent this month? $_____

18.
- Do you have an eviction notice or notice to pay or quit? ☐ YES ☐ NO
- Have your utilities been shut off or do you have a shut-off notice? ☐ YES ☐ NO
- Will your food run out in 3 days or less? ☐ YES ☐ NO
- Do you need essential clothing, such as diapers or clothing needed for cold weather? ☐ YES ☐ NO
- Do you need help with transportation to get food, clothing, medical care or other emergency item(s)? ☐ YES ☐ NO

- I certify that I have been given a copy of the coversheet. I understand and agree that I have to comply with eligibility rules, some of which I may be asked to do before any aid can be given. I understand the statements I have made on this form may be checked and verified.
- I certify that if I have applied for Food Stamps the county has told me of my right to Expedited Service.
- **I declare under penalty of perjury under the laws of the United States of America and the State of California that information I have given on this form is true, correct, and complete.**

19. SIGNATURE (OR MARK) OF APPLICANT OR AUTHORIZED REPRESENTATIVE — DATE SIGNED

SIGNATURE OF WITNESS TO MARK OR INTERPRETER — DATE SIGNED

## COUNTY USE ONLY

COUNTY OF APPLICATION

CO OF RESIDENCE (IF DIFF)

DATE RECEIVED

**TYPE OF APPLICATION:**
**CA:** ☐ AFDC ☐ RCA
**FS:** ☐ Initial ☐ Recert ☐ Rest
**MC:** ☐ **CMSP:** ☐

**Homeless:**
FS: ☐ YES ☐ NO
AFDC: ☐ YES ☐ NO ☐ CA 42

☐ Pickle Screening

**Ethnic Group:**

**Primary Language:**

☐ Presumptive Eligibility Input

☐ **Referral Date:**

**AFDC IN**
☐ Denied/NOA prep
☐ Approved
☐ Expedited Grant
☐ Applicant requested CWD to complete
(_____)
(Initials)

**FS E.S.**
☐ E.S. questions not completed
☐ Screened for E.S.
Date_____
(_____)
(Initials)

**FS Referral for:**
☐ E.S. Processing
☐ Regular Processing

☐ CWD records cleared
☐ MEDS CDB cleared
☐ IEVS initiated

☐ Copy of SAWS 1 and coversheet given to applicant

CASE NAME

CASE NUMBER